(C) A facility with a valid Medicaid participation agreement in effect after December 31, 1994, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which re-enters the Medicaid Program, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to re-entry into the program as described in subsection (13)(A). This prospective rate shall be effective for service dates on and after the effective date of the re-entry following a voluntary or involuntary termination.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this plan, a facility's reimbursement rate may be adjusted as described in this section.

(A) Global per diem rate adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments, i.e., trend factors. Global per diem rate adjustments shall be added to the specified cost component ceiling.

1. FY-96 negotiated trend factor:

A. Facilities with either an interim rate or prospective rate or prospective rate in effect on October 1, 1995, shall be granted an increase to their per-diem effective October 1, 1995, of 4.6% of the cost determined in paragraphs (11) (A) 1., (11) (B) 1., (11) (C) 1. and the property insurance and property taxes detailed in paragraph (11) (D) 3., of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12) (A) 2., that is in effect on October I, 1995, shall have their increase determined by subsection (3) (S) of this regulation.

2. FY-97 negotiated trend factor:

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1996, shall be granted an increase to their per diem effective October 1, 1996, of 3.7% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of this regulation.

3. NFRA. Effective October 1, 1996, all facilities with either an interim rate or a prospective rate shall have its per diem adjusted to include the current NFRA as an allowable cost in its reimbursement rate calculation.

4. Minimum wage adjustment. Effective for payment dates on or after November 15, 1996, an increase of two dollars and fory-five cents ($2.45) shall be granted to a facility's per diem to allow for the change in federal minimum wage. Utilizing fiscal year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty cent ($.50) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the Director of Nursing, the Admininstrator and Assistant Administrator.

(B) Special per diem rate adjustments. Special per diem rate adjustments may be added to a qualifying facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Patient Care Incentive. Each facility with a prospective rate on or after January 1, 1995, shall receive a per diem adjustment equal to 10% of the facility's allowable patient care per diem subject to a maximum of 130% of the patient care median when added to the patient care per diem as determined in subsection (11)(A). This adjustment will not be subject to the cost component ceiling of 120% for the patient care median.

2. Ancillary Incentive. Each facility with a prospective rate on or after January 1, 1995, and meets one of the following criteria shall receive a per diem adjustment:

A. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is below 90% of the ancillary median, the adjustment is equal to one-half of the difference between 120% and 90% of the ancillary median. The following is an illustration of how the ancillary per diem adjustment is calculated:

120% of median	$ 6.62
90% of median	$ 4.97
Difference	$ 1.65
1/2 the difference	2
Per Diem Adjustment	$ .83

B. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is between 90% and 120% of the median, the adjustment is equal to one-half of the difference between 120% of the median and the facility's allowable ancillary per diem. The following is an illustration of how the ancillary per diem adjustment is calculated:

90% of median	$ 4.97
120% of median	$ 6.62
ancillary per diem	$ 5.21
Difference	$ 1.41
1/2 the difference	2
Per Diem Adjustment	$ .71

3. Multiple Component Incentive. Each facility with a prospective rate on or after January 1, 1995, and meets the following criteria shall receive a per diem adjustment:

A. If the sum of the facility's patient care per diem and ancillary per diem, as determined in subsections (11)(A) and (11)(B), is greater than or equal to sixty percent (60%) but less than or equal to eighty percent (80%), rounded to four decimal places (.5985 or .8015 would not receive the adjustment), of the facility's total per diem, the adjustment is as follows:

"Substitute per letter dated 10/27/95"

Percent of Total Per Diem Rate	Incentive
< 60%	$0.00
> or = 60% but < 65%	$1.15
> or = 65% but < 70%	$1.30
> or = 70% but < 75%	$1.45
> or = 75% but < or = 80%	$1.60

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (13)(B)3.A. and the following calculation is greater than seventy-five percent (75%), rounded to four decimal places (.7485 would not receive the adjustment): Medicaid days divided by the licensed nursing facility patient days from the facility's desk audited and/or field audited 1992 cost report. The adjustment is as follows:

Calculated Percentage	Incentive
< 75%	$0.00
> or = 75% but < 80%	$0.15
> or = 80% but < 85%	$0.30
> or = 85% but < 90%	$0.45
> or = 90% but < 95%	$0.60
> or = 95%	$0.75

4. 1967 Life Safety Code (LSC). Currently certified nursing facilities that must comply with a recent interpretation of paragraph 10-133 of the 1967 Life Safety Code (LSC) which requires corridor walls to extend to the roof deck or achieve equivalency under the Fire Safety Evaluation System (FSES) will be reimbursed the reasonable and necessary cost to meet those standards required for compliance through their reimbursement rate. The reimbursement shall not be effective until the Division of Aging has confirmed that the corrective action to comply with the 1967 LSC or FSES is operational and has reviewed the cost for compliance. Fire sprinkler systems shall be reimbursed over a depreciation life of 25 years, and other alternative corrective action will be reimbursed over a depreciable life of 15 years. The Division will use a desk audited and/or field audited cost report with the latest period ending in calendar year 1992 which is on file with the Division as of December 31, 1993. This adjustment will be computed based on the documented cost submitted to the Division as follows:

A. Depreciation. The cost incurred for the approved corrective action to continue in compliance divided by the depreciable useful life.

B. Interest. The interest cost incurred to finance this project shall be documented by a statement from the lending institution detailing the total interest cost of the loan period. The total interest cost will be divided by the loan period on a straight line basis.

C. The total of subparagraph (13)(B)4.A. and (13)(B)4.B. will be divided by twelve (12) and then multiplied by the number of months covered by the 1992 cost report. This amount will be divided by the greater of actual patient days from the 1992 cost report or eighty-five percent (85%) of the licensed bed days from the 1992 cost report.

5. Any facility that had a 1967 Life Safety Code adjustment included in their December 31, 1994, reimbursement rate shall have that adjustment added to their January 1, 1995, reimbursement rate.

6. Replacement Beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Division of Aging or the Department of Health. The facility shall provide documentation from the Division of Aging or the Department of Health that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the replacement beds being placed in service and the capital component per diem (Fair Rental Value, FRV) including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

7. Additional Beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the additional beds being placed in service and the capital component per diem (Fair Rental Value, FRV) including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is calculated for the additional beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

8. Extraordinary Circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the Division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate and documented records satisfactory to the Division. If the Division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the Division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

A. When the provider can show that it incurred higher costs due to circumstances beyond its control, the circumstances were not experienced by the nursing

home industry in general and the costs have a substantial cost effect.

B. Extraordinary circumstances include:

(I) Natural disasters such as fire, earth-quakes and flood that are not covered by insurance and that occur in a federally declared disaster area; and

(II) Vandalism and/or civil disorder that are not covered by insurance.

C. The rate increase shall be calculated as follows:

(I) The one (1) time costs, (costs that will not be incurred in future fiscal years):

(a) To determine what portion of the incurred costs will be paid, the Division will use the patient occupancy days from latest available quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstances occurred; and

(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)8. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived.

(II) For on going costs (costs that will be incurred in future fiscal years): On going annual costs will be divided by the greater of: annualized (calculated for a twelve (12) month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost

component ceiling. The rate adjustment, subject to ceiling limits will be added to the prospective rate.

(III) For capitalized costs, a capital component per diem (Fair Rental Value, FRV) will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the extraordinary circumstances and the capital component per diem (Fair Rental Value, FRV) including the extraordinary circumstances.

(C) Conditions for prospective rate adjustments. The Division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

1. Fraud, misrepresentation, errors. When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's prospective rate may be both retroactively and prospectively reduced if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher, prospective rate than the facility would have received in the absence of such information. No decision by the Division to impose a rate adjustment in the case of fraudulent, misrepresented or inaccurate information shall in any way affect the Division's ability to impose any sanctions authorized by statute or plan. The fact that fraudulent, misrepresented or inaccurate information reported did not result in establishment of a higher prospective rate than the facility would have received in the absence of this information also does not affect the Division's ability to impose any sanctions authorized by statute or plan;

2. Decisions of the Administrative Hearing Commission, or settlement agreements approved by the Administrative Hearing Commission;

3. Court Order; and

4. Disallowance of federal financial participation.

"Substitute per letter dated 10/27/95"

(14) Exceptions.

(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of less than one thousand (1,000) patient days for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level of care by the state in which the provider is located; or

2. For providers which provided services of one thousand (1,000) or more patient days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of:

A. The rate paid for comparable services and level of care by the state in which the provider is located; or

B. The rate as calculated in sections (11), (12) and (13).

(C) The Title XIX reimbursement rate for hospital based providers, which provide services of less than one thousand (1,000) patient days for Missouri Title XIX recipients, relative to their fiscal year, are exempt from filing a cost report as prescribed in section (10).

1. For hospital based nursing facilities that have less than 1,000 Medicaid patient days, the rate base cost report will not be required. The prospective rate will be the sum of the ceilings for patient care, ancillary and administration, working capital allowance, and the median per diem for capital. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

2. For hospital based nursing facilities, that have less than 1,000 Medicaid patient days, with a provider agreement in effect on December 31, 1994, a prospective rate shall be set by one of the following:

A. If the hospital based nursing facility notifies the Division, in writing, and request that their prospective rate be determined from their 1992 desk audited and/or field audited cost report as defined in sections (11), (12) and (13); or

B. The sum of the ceilings for patient care, ancillary, administration and working capital allowance, and the median per diem for capital from the permanent capital per diem in effect January 1, 1995. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

(15) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this plan, the Division may also impose sanctions against a provider in accordance with state plan 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or plans.

(B) Overpayments due the Medicaid Program from a provider shall be recovered by the Division in accordance with state plan 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services.

(16) Appeals. In accordance with sections 208.156, RSMo 1986, and 622.055, RSMo (Supp. 1989), providers may seek hearing before the Administrative Hearing Commission of final decisions of the Director or the Division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these plans and other applicable payments.

(18) Provider Participation. Payments made in accordance with the standards and methods described in this plan are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these services are available to the general public.